STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145222	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlight Hlthcr of Woodstock	309 McHenry Avenue Woodstock, IL 60098

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35174 Based on observation, interview, and record review the facility failed to ensure a resident was allowed to stay in there room. This failure applies to 1 of 7 residents (R1) reviewed for room transfers in a sample of 7. The findings include: R1's Electronic Medical Record showed R1 is a cognitively intact [AGE] year old female who was admitted to the facility into a room on the 300 hallway. On 12/30/24 at 08:45 AM, R1 stated on 12/24/24 V1 Administrator came to R1's room, and told R1 they had to move to a different room. R1 stated V1 told her it was because they needed the room for a COVID positive resident. R1 stated she had been in that room since she was admitted to the facility in mid September. R1 stated she told V1 she did not want to move to a different room which ended up in an argument. R1 stated she was asked again on 12/25/24 about moving rooms. R1 stated she told V1 she did not want to move. R1 stated on 12/27/24 she was out on pass. R1 stated she left the facility around 10:00 AM with V5 (R1's driver), and returned sometime before dinner. R1 stated V15, Social Services Director, called her around 12:15 PM (R1 showed cell phone call). R1 stated V15 said her belongings were going to be moved to a different room. R1 stated she was mad at the time because she told them before she did not want to change rooms. R1 stated when she came back to the facility her things were already moved into a different room. R1 stated she did not give permission to move her things. On 1/2/25 at 09:15 AM, V15 stated she did call R1 on 12/27/24. V15 could not recall what time it was. V15 stated she called R1 while she was out of the facility per the request of V1 to let her know they were moving her things. V15 stated R1 told her she still did not understand why she had to move rooms, and was not very happy about it. V15 stated she did not recall if R1 stated it was okay, or not okay to move her things. On 12/30/24 at 1:55 PM, V13, Receptionist, stated on 12/27/24 R1 left the facility around 10:00 AM. V13 stated he remembered R1 leaving because it was the first day of the new sign in/out sheet, and she was the only resident who left that day. V13 stated R1 left with V5 who signed out R1, but put the time out on the sign in spot by mistake. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility undated Sign In/Out sheet showed R1 had signed out of the facility on 12/27/24 at 9:52 AM. On 12/30/24 at 09:15 AM, V3, Registered Nurse, stated she worked the day shift on 12/27/24. V3 stated V1 and an agency Certified Nursing Assistant (CNA) had moved R1's belongings to a new room down the hall. V3 stated she was present when R1 told V1 on 12/25/24 she did not want to move to a new room. V3 stated V1 told V7 CNA and myself R1 had been notified about the move. V3 stated R1 was out of the building when her items were moved to the new room. V3 stated R1's room had a connecting bathroom to R7's room. R7 was COVID positive at the time, but R7 was bed bound and did not use the bathroom. The bathroom door was closed for R1's safety. R7 was in that room less than 24 hours. R7 was sent out to the hospital for COVID complications. On 12/30/24 at 11:30 AM, V7 stated on 12/27/24, V1 ask the agency CNA (could not remember name) to help him move R1's belongings to another room. V7 stated she was aware R1 told V1 previously she did not want to move rooms. V7 stated R1 said nothing about moving rooms prior to R1 leaving the facility. V1 moved R1's belongings while R1 was out of the building. The Facility's Infection Control Policy for COVID-19 revised on 10/15/24 does not mandate a COVID-19 positive resident requires a private room, but is preferred if possible. This Policy does not stipulate a COVID negative resident has to give up a single room for a positive resident. The Facility's Change of Room or Roommate Policy revised 11/2024 showed prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advanced notice of such a change as is possible. The Facility's Action Summary Report printed on 12/30/24 showed R1 was transferred to another room on the 300 unit on 12/27/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35174 Based on interview and record review the facility failed to ensure a resident was free from verbal abuse which applies to 1 of 7 residents (R1) reviewed for verbal abuse in a sample of 7. The findings include: R1's Facility assessment dated [DATE] showed R1 is a cognitively intact [AGE] year old female resident admitted to the facility on [DATE]. On 12/30/24 at 9:00 AM, R1 stated on 12/24/24 V1 had come to her room and told her she needed to move rooms. R1 stated she did not want to move. R1 stated sometime after 4:00 PM, V1 came back and started arguing with her about changing rooms. R1 stated at one point V1 closed the door and started yelling at her about moving my belongings to another room. R1 stated it made her worried when he shut the door, came closer to her, and started yelling at her she had to move rooms. R1 stated V8 Registered Nurse opened the door, and V1 left. R1 stated she was mad after V1 left the room. On 12/30/24 at 10:30 AM, V1 stated he did go into R1's room to try to get her to move so they could use the room for a COVID-19 positive resident. V1 stated R1 would not move rooms. V1 stated there were several attempts to ask her to move. V1 stated the facility at one point contacted the police to have them come in and tell her she had to move rooms. V1 stated in the afternoon he did go into R1's room to move some of her things, and they started arguing. V1 stated he did close the door when he went into the room. On 12/30/24 at 3:30 PM, V8 Registered Nurse (RN) stated on 12/24/24 she was working the PM shift. V8 was outside R1's room reviewing some of her resident's medication orders. V8 stated V1 went into R1's room sometime around 4:30 PM. V1 closed the door to R1's room which made her very nervous. R1 and V1 started arguing about R1 changing rooms. V8 stated you could not hear some of the words they were saying, but they were yelling loud enough some of the residents in the hall were looking toward the room. V8 stated V1's tone and volume were inappropriate to be used with a resident. V8 stated she opened the door to the room when the yelling had increased. V1 left the room. R1 appeared to be angry and frustrated. V8 stated she knew there was a problem with how V1 had yelled at R1, but was not sure who to notify. V8 stated V2 Director of Nursing was in the building, and assumed she was taking care of it. V8 stated she checked on R1 several times during the shift. V8 stated R1 was angry and upset about the situation until the near the end of the shift. On 12/30/24 at 3:25 PM, V5 (R1's driver) stated around 4:20 PM he dropped some pop and chips off to R1. V5 stated when he was dropping off the pop, V1 had come into the room and started arguing with R1 about moving rooms. V5 stated they started to get really loud. V5 stated he started to walk toward the door, and a nurse opened it to see what was going on. V5 stated he left after the incident. On 12/30/24 at 3:15 PM, V10, RN, stated he was at the other nurses station on the 100-200 side. V10 stated you could here some arguing from the other end of the hallway. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/2/25 at 8:30 AM, R3 stated on Christmas Eve (12/24/24) she heard yelling from down the hall. R3 stated R5 and herself were talking by her room door at the other end of the hall. R1 and V1 were arguing about R1 moving rooms. R3 stated you could not hear the exact words, but you could definitely hear them yelling at each other. On 1/2/25 at 1:45 PM, R5 stated on 12/24/24, he was down talking with R3 by their room. There was yelling at the other end of the hallway. R1 and V1 were arguing about R1 moving her room. The door opened and closed so the volume changed, but they were definitely arguing. The facility's undated floor plan show a distance scale set in 5 foot increments. The distance measured from R1 to R3's room is approximately 75-85 feet. The distance measure from R1's room to the 100-200 nurses station is approximately 140 feet. On 1/2/25 at 2:00 PM, V1 stated it was not acceptable to be in R1's room raising his voice at her. The facility Abuse Policy reviewed on 2/16/22 showed It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35174 Based on interview and record review the facility failed to report an allegation of abuse to the facility designee and failed to report an allegation of abuse to the State Agency in a timely manner which applies to 1 of 7 residents (R1) reviewed abuse notification in a sample of 7. The findings include: R1's Facility assessment dated [DATE] showed R1 is a cognitively intact [AGE] year old female resident admitted to the facility on [DATE]. On 12/30/24 at 9:00 AM, R1 stated on 12/24/24 V1 had come into her room and started yelling at her about moving rooms. V1 came into the room and closed the door. R1 stated V1 came over, went to pick up my pop off the floor. R1 stated she went to pull the pop away from V1. R1 stated V1's arm and the pop struck her in the face. R1 stated she yelled Ow, you hit me! then V1 stated No, you pulled me!. On 12/30/24 at 10:30 AM, V1 stated he did go into R1's room to try to get her to move so they could use the room for a COVID-19 positive resident. R1 stated she did not want to move. V1 stated when he was in the room he went to move some pop R1 had on the floor. V1 stated he went to pick up the pop, R1 pulled him, and his arm and the pop contacted R1's face. V1 stated R1 accused me of hitting her. V1 stated he was just trying to pick up the pop when she pulled on him. On 12/30/24 at 3:30 PM, V8 (Registered Nurse) stated on 12/24/24 she was working the PM shift. V8 was outside R1's room reviewing some of her resident's medication orders. V8 stated V1 went into R1's room sometime around 4:30 PM. V1 closed the door to R1's room. R1 and V1 started yelling at each other. V8 stated at one point she heard R1 yell Ow, you hit me!, and V1 yelled something like No, you did that not me!. V8 stated she opened the door right away, and V1 left. She knew V2 Director of Nursing was in the building, and saw her talking to R1 later. V8 believed things were being taken care of. V8 stated she knew you need to report an allegation of abuse right away to the Director of Nursing or the Administrator. V8 stated she was unsure of who to talk to if the alleged person was the Administrator. On 12/30/24 at 1:55 PM, V13 (Receptionist) stated on 12/24/24 there was some yelling down the hall. R1 and V1 were arguing about moving R1 to a new room. R1 did not want to go. V13 stated V2 was still in the building talking with V1 after the argument. V13 stated he was not sure who to notify when the administrator is the one accused of abuse. V8 stated allegation of abuse are supposed to be reported right away. On 12/30/24 at 2:35 PM, V4 (Chief Executive Officer) stated he is the next person in the chain of command for the facility. V4 stated he was aware R1 was being difficult with their room change, and was arguing with V1. V4 stated he was not informed V1 had closed the door to R1's room and was yelling at R1. V4 stated he knew a final report was sent out on 12/27/24 to State Agencies (SA), but did not know if initial report was started on 12/24/24 when the incident occurred. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's undated Abuse Tracking Log showed R1's allegation of abuse occurred on 12/24/27 with a final report completed on 12/27/24. The facility's Final Report Summary dated 12/27/24 showed no documentation was sent on 12/24/24 for an initial report. This Report showed the only notification to the State Agency was on 12/27/24. The facility's Abuse Policy dated 2/16/22 showed allegations involving abuse or result in serious bodily injury should be reported immediately but not longer that 2 hours after an allegation has been made.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 35174 Based on interview and record review the facility failed to initiate an investigation after an allegation of abuse and failed to remove an alleged perpetrator from the building following an allegation of abuse for 1 of 7 residents (R1) reviewed for abuse investigations in a sample of 7. The findings include: 1. The facility final Incidents Report showed R1's documentation was sent to (State Agency) on 12/27/24. This report showed the police were called to the facility and found no evidence to substantiate the allegation of physical abuse. The report showed no entries of any verbal allegations of abuse. On 12/30/24 at 10:30 AM, V1 (Administrator) stated the police were in the facility after R1 said V1 struck her. V1 stated the police talked to myself, and they said R1 had no signs of physical abuse. The police who came said it was unsubstantiated. V1 stated he sent all the information about the incident to (State Agency) On 12/30/24 at 3:25 PM, V5 (R1's driver) stated he was in the room when R1 and V1 were yelling at each other. V5 stated his back was to R1 and V1 when R1 said she got hit. V5 stated none of the staff had asked him anything about that day. On 12/30/24 at 3:30 PM, V8 Registered Nurse Stated she was the nurse on duty for most of the 300 hallway when R1 and V1 had their argument. V8 stated she was not interviewed by anyone in the facility the incident. During the investigation, the facility did not produce any documentation showing they had completed an independent investigation pertaining to the 12/24/24 allegation of V1 striking R1. 2. On 12/30/24 at 3:30 PM, V8 (Registered Nurse/RN) stated R1 and V1 Administrator were yelling and arguing in R1's room with the door closed. V8 stated she heard R1 yell Ow, you hit me, and V1 say something like No, you did that! V8 stated she immediately opened the door, and R1 and V1 were close to each other. V1 left the room. V8 stated she was not sure who to notify if the accused staff was the Administrator. V8 stated she saw V2 talking with V1 later so she thought things were being taken care of. V8 stated if a staff member is the accused they should be removed from the building until an investigation is completed. V8 stated V1 returned at least once to R1's room after the incident. V8 was not sure when V1 left the facility. V8 stated yelling at a resident and a resident saying someone hit them are example of allegations of abuse. On 12/30/24 at 9:15 AM, V3 (RN) stated she worked on 12/25/24. V3 stated V1 was working in the afternoon on 12/25/24 when they came into the facility for the PM shift. V3 stated she was not aware of what time V1 left the building on 12/25/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/24 at 11:30 AM, V7 (Certified Nursing Assistant) stated she worked on 12/25/24. V7 stated she had heard V1 and R1 had some sort of incident. V7 stated she was surprised V1 was in the building on 12/25/24. V7 stated she thought a staff member could not come back until an investigation was done after an allegation of abuse. On 1/2/25 at 2:00 PM, V1 stated he waited to talk to the police after R1 had called them after saying he struck her with the pop. V1 stated he left the building some time after 6:30 PM on 12/24/25. He stated he worked the entire time and was not taken off work because no investigation was done. On 1/2/24 at 10:00 AM, V2 (Director of Nursing) stated she had left the building after 6 PM. V2 stated V1 was still in the building when she left. Staff are usually sent out right away and an investigation started. V1 probably should have been sent home. The facility's Abuse Policy dated 2/16/22 showed to protect the resident by making room or staff changes to protect the resident from the alleged perpetrator.